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| Patient Care Coordination | **Last Revision:** | March 2020 |
| **Last Reviewed:** | March 2020 |
| **Applies to the following THA Group of Companies:** | * Island Health Care * Island Hospice * Independent Life at Home * RightHealth® * Palliation Choices |
| **Included in the following THA Manual:** | Administrative Policies & Procedures  Provision of Care, Treatment & Service |

## POLICY

All disciplines providing patient care collaborate as needed to ensure continuity of services and promote optimal clinical outcomes.

**PROCEDURE**

1. Each clinician is responsible for facilitating communications about changes in the patient’s status among all assigned personnel
2. Patient changes are communicated to the State Director in a timely manner via telephone, email, RN/Therapy team quality meetings, team conferences, or home visits. The patient’s physician of record is notified immediately of acute changes in patient condition.
3. As appropriate, documentation of communications will be included in the patient’s clinical record. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.
4. RN/Therapy team quality meetings are held on a routine basis. RN/Therapy partners are required to attend in person and other clinical staff may call in to participate.
   1. Items of discussion during quality meetings will include, but will not be limited to, the type and frequency of service by each discipline involved, changes in the patient’s overall status, problems/issues, possible resolutions, progress toward goals and any necessary revisions to the plan of care. The patient’s physician of record is contacted for approval of all proposed changes to the plan of care.
   2. A record is kept indicating who participated in case conference and which patients were discussed.
   3. Hospice conducts bi-weekly IDT meetings to collaborate on patient care and includes the Medical Director, RN Case Managers, Social Work, Spiritual Care, and Volunteers, as well as input from sources related to patient care.
5. All clinicians involved in patient care have access to the patient’s record for review of clinical documentation, clinical summaries, and/or communication notes.